PROGRESS

VOLUME III NUMBER 2 SEPTEMBER, 1961

IN THIS ISSUE

AWARENESS · KNOWLEDGE · UNDERSTANDING · PREVENTION

THE ALCOHOLISM FOUNDATION OF ALBERTA

CALGARY CLINIC
737 - 13th Avenue S.W.
Telephone AMherst 9-6101

ADMINISTRATIVE CENTRE
AND EDMONTON CLINIC
9910 - 103rd Street
Telephone GArden 4-7161

The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual Prevention of Alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

TREATMENT

Treatment services are available to anyone desiring help with a drinking problem. The treatment program includes individual counselling, medical treatment, and group therapy. A service fee of $10.00 is charged to the patient. No patient is ever denied treatment due to inability to pay.

There are no consulting fees.

Edmonton and Calgary out-patient clinic hours — 9 a.m. to 5 p.m.
Monday through Friday.

The Alcoholism Foundation of Alberta

Executive Director—MR. J. GEORGE STRACHAN

PROGRESS

Volume III, Number 2, Edmonton, September, 1961

Editor: T. G. COFFEY

Assistant Editor: D. PROCTOR

PROGRESS is published four times a year as part of the Foundation's Educational program. All material in PROGRESS is believed to have been obtained from reliable sources, but no representation is made as to the accuracy thereof. Opinions expressed in the articles themselves are not necessarily those of The Alcoholism Foundation of Alberta, but are those of the authors reported.

Requests for permission to reprint articles from PROGRESS are welcomed.

Manuscripts are invited on the understanding that no fees can be paid.

Persons desiring to receive PROGRESS regularly (there is no charge) should write to:

PROGRESS
9910 - 103rd Street
Edmonton, Alberta

CONTENTS

NEWS BRIEFS

FOUNDATION NEWS

Alberta was well represented at the 19th Yale Summer School of Alcohol Studies held this July.

Four Foundation staff members attended: Publications Editor, T. G. Coffey and Information Officers, H. Smart, M. E. Dale and C. R. Dickey. Non-staff members sponsored by the Foundation were Professor A. W. Eriksson, University of Alberta, and Rev. J. Cashen, O.M.I., Lethbridge.

The new Information and Referral Centre for Southern Alberta was opened at Lethbridge in September. Hugh S. Smart, former Information Officer of the Calgary Clinic, is in charge.

Employment Counsellors and Placement Officers in the Edmonton office of the National Employment Service in June were given the last of a series of six lectures on alcoholism and related problems by Foundation staff. About thirty NES officers participated.

For the first time, the Foundation was invited to supply a lecturer on alcohol and alcoholism education for the annual Summer School of the Faculty of Education, University of Alberta. Two full sessions were devoted to this project.

NAAAP ANNUAL MEETING

The North American Association of Alcoholism Programs will hold its annual meeting in Chicago in November. Attending from The Alcoholism Foundation of Alberta will be Mr. J. G. Strachan, Executive Director and Mr. J. P. Matheson, Deputy Director.

CLERGY SURVEY

The Episcopalian, national monthly magazine of the Protestant Episcopalian Church in the U.S. reports that alcoholism is the major problem being brought to its clergymen for assistance.

A recent survey of 7,000 clergymen serving 3,400,000 Episcopalians showed that they ranked the major problems with which they are called upon to deal as: alcoholism, family difficulties, and personal crises.

GOVERNMENT STUDIES ALCOHOLISM

The Legislature of Quebec recently set up a committee to study the subject of alcoholism. Minister of Family and Social Welfare, Emilien Lafrance, marking this as a historic stage in the struggle against alcoholism in Canada said: "For the first time . . . the State recognizes its responsibility in the objective study of this problem (alcoholism); it also recognizes the need to keep the public informed."

DOCTOR RESIGNS

Dr. Humphrey Osmond, Superintendent of the Saskatchewan Hospital at Weyburn, has resigned to return to England. Dr. Osmond is co-author with Dr. Abram Hoffer of the book, **The Chemical Basis of Clinical Psychiatry.** He is well-known for his pioneering work with LSD and his treatment of alcoholics.

ALCOHOLISM STANDING DROPS

B.C.'s rate of alcoholism is no longer the highest in Canada, having dropped from 2,495 cases per 100,000 adults to 2,160. According to the report of the Alcoholism and Drug Addiction Research Foundation, the alcoholism rate in Quebec and Ontario of 2,350 cases per 100,000 is now the nation's highest. The rate in Alberta is estimated at 1,550 per 100,000.

WINE CHEAPER THAN FRUIT JUICE

The average French café charges only 6¢ for a glass of wine, while a glass of fruit juice will cost between 25¢ and 32¢. Jacques Romieu, of the Consumers' Union of France suggests that this is a reason for the intemperate wine drinking in that country. He states that as long as fruit juice remains a drink only the wealthy can afford, "our national fight against alcoholism will not be won."

BARMAIDS IN WINNIPEG

Three barmaids are working in Manitoba beverage rooms and "are having a good effect on the customers," a Canadian Press story reports. D. W. Safer of the New Occidental Hotel says that his two barmaids, both married women, "have worked out very well. The women are courteous and the men find themselves being polite in return."

COMPANY PROGRAM FOR ALCOHOLIC WORKERS

"Our experience indicates that recovered alcoholics are among the ablest and most conscientious of our employees," says Bruce Mansfield, Vice-President of Ohio Edison Co. "We believe that a company program to help the alcoholic employee is completely justified . . . and is surely in the best interests of good management."

ALCOHOL, SCIENCE AND SOCIETY

By Milton A. Maxwell

Condensed from an address to the Eighth Annual Membership and Board Meeting of the Alcoholism Foundation of Alberta, May 15, 1961.

AT THIS annual meeting, we have reviewed the past year. We have also taken note of how far we have come since the Foundation opened its doors in 1953. Now I invite you to look at the Foundation from a still larger perspective—to see the Foundation's past, present, and future in the context of the larger movement tackling the problem of alcoholism, a movement which is just over a quarter of a century old.

As a sociologist, I see this larger movement as a genuine social movement: aimed at bringing about certain changes in our society. Specifically, it is aimed at a better understanding of alcoholism, a change in attitude toward the alcoholic, his treatment, and generally a 'new deal' for the alcoholic. The aim ultimately is a substantial reduction in alcoholism.

Credit for sparking this movement belongs primarily to Alcoholics Anonymous and to the Yale Center of Alcohol Studies. We have to keep in mind that in 1935 little hope could be offered alcoholics. Then came AA which has not only helped thousands of alcoholics to recover (well over 400,000), but has also dramatized, for all to see, the possibility of recovery. Many of these recovered alcoholics, in turn, have given and still are giving much time and energy to the development of public and voluntary programs which now exist in almost every province and state.

Equally important to the total movement was the Yale Center of Alcohol Studies which, in 1935, was beginning a strictly scientific approach to the problems of alcohol and alcoholism. After over a century of emotional, wet-dry controversy, dependable knowledge was sorely needed. This, Yale set out to

provide through its own research, through the *Quarterly Journal of Studies on Alcohol,* through the Summer Schools of Alcohol Studies, through the founding of what is now the National Council on Alcoholism, through the development of the first out-patient medical-psychological clinic, through stimulating in Connecticut the first tax-supported program. Thus the Yale-plan clinic and the Connecticut program provided influential models for other states and provinces to follow. Through the years, Yale has been the scientific and educational fountainhead of the larger movement of which our Foundation is a part.

THE SCOPE and strength of this still growing movement was clearly to be seen at the 1960 Banff meeting of the North American Association of Alcoholism Programs which was hosted by our Foundation and the Province of Alberta. At this historic meeting, all the major Canadian and American organizations and personalities in the alcoholism field met together for the first time. Not only the leaders of the various provincial and state programs, but Bill W., the co-founder of Alcoholics Anonymous; Marty Mann and Brinkley Smithers, the leaders of the National Council on Alcoholism; Dr. E. M. Jellinek, the much-honored 'Dean' of modern alcohol studies; Dr. Marvin Block, the spark of the American Medical Association sub-committee on alcoholism; Dr. Nevitt Sanford, the scientific director of the new "Co-operative Commission" research project; Carl Anderson and James Fox, the representatives of the National Institute of Mental Health which has provided the $1,100,000 for the Co-operative Commission project. And there were many others. One could feel the growing force of this many-faced movement and the growing unity and sense of direction.

Sometimes, we who are deeply terested in the problem of alcoholism feel that the movement is coming along too slowly. But, as a sociologist, I have learned how slowly social changes usually come. And, compared to other social changes which involve changes in deep-seated attitudes, long-believed and emotionally-charged 'facts,' I believe we are moving along not only at a respectable, but even a heartening, speed.

But, at this annual meeting, we are concerned not only with the Foundation's accomplishments, present scope, and speed, but also its future direction. What guidance for the Foundation's future can we gain from a knowledge of other social movements and from what we know about society and social change?

A REVIEW of the Foundation's history shows that treatment and education have been central in its program. Each succeeding year has seen more patients going through our doors and an increase in both the volume and variety of

educational activities. In years past, there has been scarcely any problem of priorities. With a limited and hard-working staff, the main problem was one of trying to keep up with the growing demands for treatment and education.

There is no question in my mind that treatment should continue to be central. We want to get help to every alcoholic who can be motivated to seek help. There is no question that education should continue. It has already produced results. The public attitude is changing to one of greater understanding, and alcoholics are coming for help earlier. But there are still so many alcoholics who need help, and so many persons who need a better understanding of alcoholism, that more treatment and more education will remain central to the Foundation's program for some time to come.

I believe most of us recognize, however, that a program of just 'more treatment and more education' is not enough. I'd like to touch upon what else is needed.

Dr. Jellinek spoke on this problem last year, making quite a few important points in his talk on "Goals of Alcoholism Programs." Reprints of this talk, published in PROGRESS, have been in demand from alcoholism programs everywhere, and I believe it deserves repeated thoughtful reading by all of us who shape the Foundation's program. There is much wise guidance in this article.

What I have to contribute this evening comes in the form of two basic 'perspectives' which have done the most to clear my own thinking about the Foundation and the large movement of which it is a part.

Institutional Change

The first perspective can be put in the form of a statement: **social changes will not be permanent unless they are incorporated in the ongoing major institutions of society.**

We have had great waves of interest in alcoholism a number of times in the past century and a quarter. Beginning in Baltimore in 1840, the "Washingtonian Movement," a somewhat AA-like movement for helping alcoholics recover, swept across the United States. It aroused tremendous interest and helped almost as many alcoholics to recovery as AA did in its first 20 years. But in seven years it had almost disappeared from sight, leaving no basic changes in the ongoing, major institutions of society. In the 1870's and 1880's, the Blue and Red Ribbon movements swept across North America with even greater force, helping even more alcoholics recover. One stream alone, Osgood's Red Ribbon movement in the 1870's, composed entirely of alcoholics, claimed 60,000 members in Massachusetts and 80,000 in Michigan. But the gains of such waves of popular interest did not become permanent because the main institutional structures of

society remained essentially unaffected.

And that's my point. No social change lasts unless the new knowledge, the new understanding and practices get into the main institutional structures: into medicine, for example, and by that I mean into the very curricula of medical schools and into the regular patterns of medical practice. So with schools of nursing, and nursing and hospital practice. So into the very training of clergymen and the standard thinking and behavior of church people. So with the social work institutions and practices, schools of law and legal practice and court procedures, colleges of education and educational curricula.

This time, we are seeing encouraging signs that the new knowledge, attitudes and practices are taking root in these institutional structures, and the Foundation is directing more of its educational effort in this direction. We are, just as an example, lecturing to Fourth Year medical students at the University of Alberta Medical School. So far, so good, but we will not have achieved permanent results until the understanding and treatment of alcoholism becomes a regular part of the curriculum of this and all medical schools, taught by the regular faculty. And so with the other major institutions.

If we can just appreciate the necessity of consolidating our gains in the regular institutional structures of society, we will have a most important and realistic guide to the Foundation's future programming. If the Foundation does its work well, and if the larger movement succeeds, the Foundation and all special alcoholism programs will eventually disappear, but the effective treatment and education will continue as a permanent part of regular health and educational institutions.

Necessity of Research

The second perspective which provides a guide to future programming is the necessity of research. This hit home when I heard a famous health educator observe that **no large health problem has ever been solved by treating victims only.** Without new knowledge on the causes and the treatment of the particular disease, we are on

Milton A. Maxwell, Ph.D., who spent a year in Alberta as Consultant and Director of Programming for the Foundation, is Professor of Sociology at Washington State University, Pullman.

an endless and hopeless treadmill —and no speed-up in treatment can get us off it. We have conquered or reduced many diseases—the major childhood diseases, for example, or tuberculosis. But it took much research to turn up the important new knowledge, and then much education to get the new knowledge to the people who could use it.

In his talk last year, Dr. Jellinek listed some of the alcoholism research needs. We are at present able to help many alcoholics, but there is still so much we need to know about the "causes" and the treatment of alcoholism. How can we more effectively motivate alcoholics to accept help? How can we better communicate with alcoholics whom we are now not reaching—or with sections of the public we are unable to reach. What change in drinking customs or legal controls would reduce the incidence of alcoholism? What mental health education is needed? What education, addressed to whom, has the greatest preventive effect?

I know how impatient many people are with slow research, and the great effort it takes to make small gains in knowledge. Even for researchers, much of the work is tedious and slow. But this perspective on the necessity of research provides us with both the justification and the motivation to keep working at it—as the Foundation has begun to do through the establishment of a functioning research department.

WHEN WE consider the two points I've made— the need for institutional change and for research—it is obvious that we cannot do all that is needed at the local or provincial level. This underscores our need to work with and through national agencies. Alcoholism education will not become a regular and permanent part of the University of Alberta Medical School curriculum unless it becomes a standard component of the teaching of all Canadian Medical schools. So it will be with institutional changes in the fields of social work, mental health, education, etc. This is the perspective which has led to the creation of the North American Association of Alcoholism Programs, to all other national and international approaches, and to the present move to establish a Canadian Foundation on Alcoholism. To succeed locally and provincially, a part of our effort needs to be spent at the national and international level. As we think about this, we see that a reasonable amount of time and money spent in the promotion of such national and international activities is not only not a waste, but a strategic investment in the future. In the long run, it means a more complete and lasting achievement of our goals.

I am pleased that our Foundation has been active in this respect and, I trust in the light of this perspective, will continue to play a vigorous role in the larger scene. In fact, I believe we are morally obligated to do our share—and, if we

can—just a little more than our share.

I hope that The Alcoholism Foundation of Alberta will be not just an ordinary program, with just more of the usual, but a leader in the total movement. And this means the making of some original contributions, via research, to better treatment methods, to better understanding which will help us help more alcoholics at earlier stages, to do better education which will be preventive. And, it means the making of strategic contributions to the consolidation of present and new understandings and practices in the institutions of our total society.

Canadian Foundation on Alcoholism

A Canadian Foundation on Alcoholism, which will centre on organizing and sponsoring research projects, is presently being formed. At a meeting in Ottawa in June, representatives of ten provincial alcoholism programs met with federal government representatives and delegates from industry, medicine, and other groups, to plan the new Foundation.

The meeting agreed that an ad-hoc committee which had met with Hon. J. Waldo Monteith, Minister of National Health and Welfare to arrange the conference, should carry on as a steering committee.

Members of the committee include: George C. Derby, President of The Alcoholism Foundation of British Columbia; J. George Strachan, Executive Director and Dr. R. MacGregor Parsons, Board Member of The Alcoholism Foundation of Alberta and the then President of the Canadian Medical Association; H. David Archibald, Executive Director of the Alcoholism and Drug Addiction Research Foundation of Ontario; and Dr. André Beaudreau of the Quebec Commission on Alcoholism.

What Shall We

Tell Our Children About Drinking?

By John Park Lee

THE "man of distinction" speaks from the pages of the slick magazines; the virtues of various alcoholic beverages are proclaimed in advertisements in the daily press; taprooms, bars, and cocktail lounges extend their invitations in every city and town; waiters suggest a drink to diners in hotels and restaurants; movies, plays, and television shows are full of drinking scenes.

Neither children nor adults escape this constant pressure, both subtle and blatant, to drink. They, as well as their parents, are being taught that the "best people" drink, that the gracious hostess serves drinks, that alcohol is essential to the conduct of business, and that ability to handle it is a mark of maturity.

Whatever parents themselves may think about the rightness or wrongness of drinking, whatever their own personal habits may be, whether or not they have and serve alcohol in their homes, they all hope that their children will never have any trouble with alcohol. Teetotaler and moderate drinker are in complete agreement in their desire that their children never get drunk, never become a threat to themselves or others, never become victims of alcoholism.

Parents also recognize that the enormous attention paid to alcohol today gives it great importance in the minds of their children. Conscious effort on the parents' part will be necessary if their children are to be prepared to cope with it. Hopes that children will not be hurt by alcohol will not be achieved by mere wishing. This is

an area in which parents must inform themselves. They must be prepared to answer their children's questions with intelligence and understanding, and must guide them into the formation of convictions and attitudes that may preserve them from future trouble.

ATTITUDES toward drinking, just like attitudes toward other important concerns of our society, are often fixed rather early. The time to begin preparing children for the social pressures they will inevitably face is before the pressures are applied. For today's children this means beginning discussions about drinking while they are still juniors—before they become adolescents and start going to parties and dating.

There is ample evidence that the overwhelming majority of persons who drink had their first drink before leaving high school. Children are being exposed to alcohol at parties at a far earlier age than in previous generations. Parents cannot postpone discussions too long.

The most effective education about alcohol that parents can provide is through their own lives. Parents must understand that they are constantly educating their children by their attitudes, their remarks at the dinner table, their behavior. Children do listen to what parents say—sometimes. But they pay much closer attention to what parents do.

Sociological studies of college boys and girls show that their drinking patterns reflect very closely the patterns of the homes from which they came. Drinking parents usually have drinking children; abstaining parents are likely to have abstaining children. There are, of course, exceptions, but the pattern is too often repeated to be accidental.

Consequently, parents must remember that their attitudes toward alcohol, their comments about drinking and those who drink, their sympathy for or intolerance toward those who have trouble with alcohol, their linking of their own behavior and attitudes with the teachings of the church of which they are members—all these are teaching the children and influencing them as they develop their own concepts and attitudes which will be reflected in later behavior.

The second thing parents must always remember is that assurance of their love is essential to the child. This is as vital when parents are talking about the use of alcohol as it is when discussing any behavior problem. No matter what the views of the parents may be concerning alcohol, the child must know both by direct comment and by assumption based on the parents' attitude that nothing he does can separate him from his parents' love.

This does not imply total permissiveness, the elimination of moral standards, or abandonment of the

responsibility of parents to set the limits within which their children think, what they want him to do, and what he may expect if he breaks over. Nothing gives a child greater security than to know such limits—provided, of course, they are reasonable and "make sense" to him. He may rebel against them, but he will be grateful for them. Nothing makes him feel more insecure and unwanted than to be given complete freedom to do what he wants.

PARENTS who do not want their children to drink should say so, and in one way their educational task is easy. It is simpler to tell a child not to do something than to try to get the idea of moderation across to him. But because it is simpler, it has pitfalls. Especially if parents themselves do not drink for moral reasons, it is easy to become censorious, self-righteous, and superior, and to leave the child with the belief that those who drink are not "nice people." But the child is going to come in contact with fine children—of differing racial, religious, and cultural backgrounds—from other fine homes — where alcohol is served. The child of the abstainer will thus be forced to choose between what his parents told him about such people and the evidence to the contrary that he discovers in his relations with these children and their parents.

The educational process is probably best carried on informally as the occasion presents, through a question the child himself asks, a TV program, something in the church school lesson, a story in a newspaper, or an incident observed on the street. Any of these things may provide the springboard.

PROBABLY THE most frequent question asked will be why people act the way they do when they drink. This gives parents an opportunity to explain the nature of alcohol as a depressant. Children understand about conscience —the mysterious "something" inside that tells them what they should and should not do. That sense of direction from within is the result of what we learn from our parents, our church, and the other people around us. Alcohol affects this directing part of us inside and makes it inattentive. Some more makes it sleepy, a lot puts it to sleep. Then the person begins to get out of control and may get into real trouble and do a lot of silly and foolish and even dangerous things—just as traffic would get all snarled up if the traffic policeman fell asleep or the signal lights no longer worked.

Because of this effect of alcohol, people realize that it can be dangerous, and many communities will not permit its sale to anyone under twenty-one. It is felt that a person should be grown up before he should attempt to handle alcohol.

"We hope," the parents may say,

"that as you grow older you will decide, as we have, not to drink. We think you will be stronger and happier, and it will certainly make us glad if you decide in this way."

The child may then ask why his parents do not drink, and this will give them an opportunity to point out how people differ on this—how many fine and good people who have different ideas think it's proper to drink, and do so.

"But your mother and I," the father may say, "believe in what our church says—that it's a matter of conscience, and we think that it's better for Christians not to drink. It makes certain that we never have any trouble with alcohol or lead anyone else to drink who may have trouble. Actually, we don't need it. We can use the money to buy other things for us here at home that we all can enjoy. And we think we have just as much fun as those who drink."

If the home is full of life and fun and happiness, this latter statement will carry a great deal of weight and be extremely important in leading the child to understand that drinking is not essential to having a good time.

PARENTS SHOULD encourage their children to discuss drinking and to bring home any questions they may have. Each new idea should receive a fair hearing; no proposition, no matter how foolish, should be brushed off. Children, like adults, like to be treated with respect.

The problem of a child's actually drinking will rarely arise at this age, but there is always the possibility. For some "dry" homes this may seem to be a genuine tragedy; the wise parent will not let the child get this impression. A youthful experiment with alcohol should be understood for what it is, and although parents may properly express their regret over the act, they will refuse to magnify it unduly. Otherwise, it will get an importance in the child's mind it would ordinarily not have. This will be even more true when the child becomes a teen-ager, when experimentation with all kinds of forbidden fruit is part of the growing-up process.

Even parents who conscientiously choose not to abstain from the use of alcohol should recognize their responsibility for setting a proper example and helping their children to know the dangers inherent in drinking. The children should be told of alcohol's nature as a depressant of physical, mental, and moral reactions, with resultant hazards from loss of control.

Children of such parents must likewise feel that no mistakes they may make will cost them their parents' love.

IN SUMMARY, it is clear that parents must discuss drinking with their children, even at the junior age. Such discussion may be

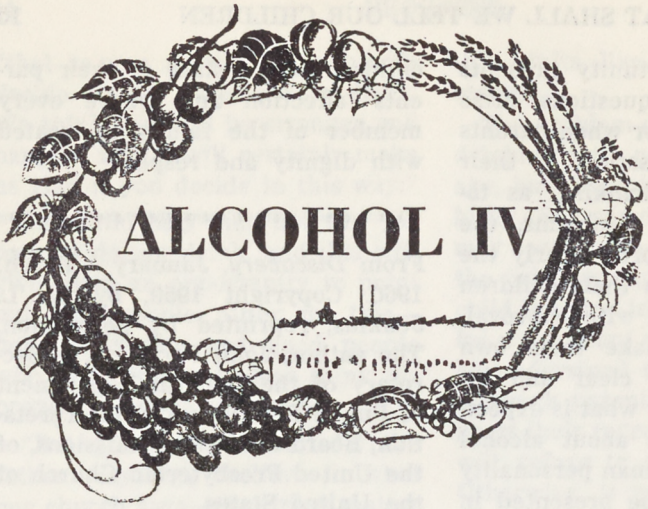
held as the opportunity presents itself, either as questions arise from the children or when parents initiate the conversation. In their approach toward drinking, as toward all behavior problems, the parents must set forth clearly the limits within which their children are free to operate with approval.

Parents must make their own convictions crystal clear and let their children know what is expected of them. Facts about alcohol and its effect on human personality and behavior can be presented in ways which children can understand, and illustrative cases can be discussed without moralism and ridicule, but with sympathy and understanding.

No one has yet produced an adequate explanation of alcoholism; no one is quite sure why people drink too much. But there is general agreement that mature people do not often become alcoholics or have other difficulties with alcohol. Nothing is more likely to produce maturity than happy homes where parents love each other, where the children feel certain of their parents' affection and where every member of the family is treated with dignity and respect.

From *Discovery*, January - March, 1960. The author, John Park Lee, is Secretary of the General Department of Public Relations and Interpretation, Board of National Missions, of the United Presbyterian Church of the United States.

The Foundation is conducting much educational work with schools and young people's groups. Lectures have been given to students in schools in eight major centres and, in conjunction with the Ontario Alcoholism & Drug Addiction Research Foundation, a film "It's Best to Know," suitable for high school students, has been produced. Other films and pamphlets, suitable for young people, are available from the Foundation centres.



PSYCHOLOGICAL EFFECTS OF ALCOHOL

by A. W. Fraser

IN THIS PAPER I will deal with the effects of small and medium amounts of alcohol on psychological function.

Hundreds of laboratory experiments have been conducted to determine the psychological effects of alcohol—and a good deal of valuable information has been uncovered. One of the most important contributions of this extensive experimentation has been to demonstrate consistently that alcohol is not a stimulant, as was believed for generations, but an anaesthetic.

As an anaesthetic, its action is primarily on the brain. The first effect of alcohol is on the highest centre of the brain, the cortex, which is the centre of judgment, reason, and emotional control. Slightly greater concentrations of alcohol in the blood affect the lower brain centres, which control muscular co-ordination and vision. As the concentration increases, stupor, and then unconsciousness, results. Still higher concentrations can cause death due to respiratory failure.

In considering the general effect of alcohol on behavior it should be remembered that people show only small differences in lower

brain centre function, but wide differences in the high brain centre function. Consequently, differences in individual behavior in conditions of deep intoxication are small, but there can be wide variations in conditions of mild intoxication.

THE GREAT majority of those who drink alcoholic beverages do so in moderation and do not become intoxicated. The fact, however, that they show no overt signs of intoxication does not mean that the alcohol they have consumed is without effect on their behavior. They may, and in most cases do, experience subjective effects such as a slight change in mood, lessened tension and anxiety, a greater feeling of ease and relaxation. These changes and consequent changes in total behavior are difficult, if not impossible, to measure quantitatively and so experimental psychologists have not dealt with them. The tests of the experimental psychologists have been limited to those components of total behavior in which changes can be measured; for example, sensory perception, judgment, co-ordination, learning, etc.

The interpretation of the results of these experiments requires some caution. Many who have read these results tend to assume that changes in a single function result in a corresponding change in total behavior. Such assumptions, of course, are unwarranted as they do not take into account the effect of possible coincidental changes in other functions or the interaction of functions. Further, in any conclusions about total behavior, the wide differences in high brain centre functions must be considered and also the fact that any particular person's reaction to a given amount of alcohol will vary from time to time depending on his prevailing mood, his physical condition, and his social situation.

Following are the findings of some experiments on the psychological effects of alcohol. In these experiments, small amounts of alcohol refer to the amount of alcohol contained in 3 ounces of distilled spirits or in 2 bottles of beer, taken on an empty stomach by a man weighing between 150 and 160 pounds, the effect being measured about one hour after consumption. Medium amounts refer to the equivalent of 6 ounces of distilled spirits or 4 bottles of beer.

Sight, Hearing, and Touch

After small amounts of alcohol, a person's sensitivity to light and sound is increased: He is able to detect softer sounds and light of smaller intensity. At the same time, however, his ability to discriminate between degrees of loudness and degrees of brightness, a task involving judgement, is diminished. Medium amounts of alcohol further impair discrimination and decrease sensitivity.

The sense of touch is neither increased nor decreased, but sensitivity to pain and the ability to

(Continued on Page 20)

LOOKING

The Foundation's achievements are considerable — comparable to the best in North America—but they are insignificant in terms of what still needs to be done. The Foundation must develop its treatment, education, and research activities if it is to contribute toward the control of this major public health problem. Treatment—Our first and most important responsibility is to the alcoholic patient. Professional staff must be trained and facilities provided within reach of all alcoholics in Alberta. Education—Effective education, reaching all professional groups and those many alcoholics still unaware of treatment facilities, is necessary if we are to do more than decrease the increase of alcoholics in Alberta. Research—No health problem has ever been reduced without research. A better understanding and treatment of alcoholism and a more effective education program can only be achieved through research.

These essential developments will only be achieved with the interest and support of an active body of members.

THE FOUNDATION NEEDS

Estimated as of 1959, twelve thousand Albertans are alcoholic—most of them still married and working, but struggling with a growing problem. Only a small proportion of these are receiving the treatment they need. Your interest and support can help the Foundation reach these people and give them the chance to recognize their problem and accept treatment.

The Foundation is a private organization incorporated under the Societies Act in 1951. To maintain this status under the Societies Act —and this is a distinct advantage to its work—the Foundation must maintain an active body of members.

The major portion of Foundation funds is derived from a grant through the Department of Health, Province of Alberta. This grant supports the treatment program and much of the educational activities of the Foundation. Membership donations are budgeted for special

AHEAD

1953 – 1961

In the eight years of its operation The Alcoholism Foundation of Alberta has developed and grown, providing professional treatment for the growing patient intake, educational services for the increasing demands for advice and information, and research studies necessary for an understanding of alcoholism.

YOUR MEMBERSHIP

educational and research activities, without which this problem will not be reduced, and for the recruitment and training of staff.

WHO MAY BE A MEMBER?

Any person, company, or association donating five dollars or more, either in cash, services, or goods, automatically becomes a member for twelve months.

WHAT ARE THE RIGHTS AND PRIVILEGES OF MEMBERS?

Each member is entitled to a vote at all general meetings of the Foundation. All members receive copies of Foundation publications, such as Progress, Annual Reports, and pamphlets and brochures as they are produced.

differentiate between points of stimulation on the skin are reduced.

These variations in perceptive abilities and the loss of sharpness in judgment are really too slight to be of much importance in practical life; but they do show the direction of the effects of alcohol. They demonstrate that judgment is susceptible to alcohol and is one of the first functions affected by it.

That small amounts of alcohol cause impairment of judgment is substantiated by other tests. For example:

(1) Accuracy in estimating length of time intervals is consistently decreased after the consumption of alcohol.

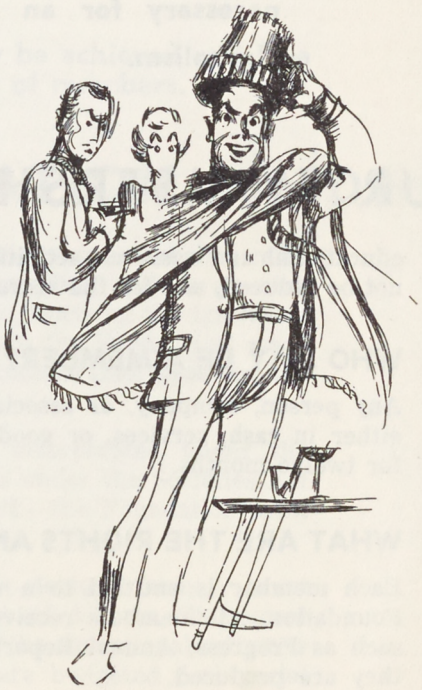
(2) In word association tests small amounts of alcohol result in an increase both in the speed and the quantity of words produced in response to given stimulus words. At the same time, however, the quality of the association suffers noticeably. This seems to indicate that alcohol results in a greater flow of superficial ideas, but a basic impoverishment of thought.

In the latter experiment, it is interesting to note, the majority of the subjects when questioned afterwards felt that they had performed much more brilliantly after their drinks than before—a situation somewhat reminiscent of many a man's inability to understand his wife's criticisms of his brilliant and witty conversation during the evening before!

Reaction Time and Co-ordination

Small amounts of alcohol increase reaction time by as much as 40%. This could represent an increase in stopping distance of 6½ feet at 30 miles per hour—and proportionately greater distances at higher speeds.

Performance involving coarse muscular co-ordination is not measurably affected by small amounts of alcohol, but performance involving fine co-ordination is impaired, and the degree of impairment in-



creases as the co-ordination required becomes more complex.

Familiar routine tasks are less affected than new and unfamiliar ones — and the effect on complex, but familiar, tasks is less than on simpler, unfamiliar, ones.

Learning

Learning ability is generally diminished by the effects of small amounts of alcohol. There is some variation, however, in the amount of decrease, depending upon the subject matter involved. New learning is more affected than old learning; difficult learning more than easy learning; and painful learning more than non-painful learning. (Painful learning may be defined as that type of learning which one finds very distasteful or emotionally distressing.)

THIS COVERS, in a limited way, the results of psychological laboratory investigations. As you can see, it has been generally confined to the effects of alcohol on those functions which may be referred to as actions. Little scientific experimental investigation has been done on the effect of small amounts of alcohol on moods or emotions. Yet involved in all these actions are emotions, and actions cannot be arbitrarily separated from emotions in any consideration of the effect of alcohol on human behavior. So although these experiments give us valuable information about the effect of alcohol on isolated functions, they do not give us too much insight into the effect of alcohol on the total behavior of an individual.

The Effect of Alcohol on Emotional Expression

It is evident that the major effect of alcohol is not on sensory function, but rather on emotional function. The fact that a person's reaction time is slowed by 40%, that he can see and hear a few hundredths of a degree more or less clearly is of minor importance —except in those actions involving skill or requiring quickness of mind and body, such as driving a car. The significant change is the reduction of feelings of anxiety and tension, a greater feeling of ease and confidence, the fact that he then feels more able to perform, to express himself, in front of others.

Such emotional phenomena as tension, anxiety, and inhibitions are controlled by the highest centre of the brain and are therefore highly susceptible to the effects of alcohol. These functions, and others, such as foresight, discretion, self-evaluation, reactions of inferiority and rejection, are all "controls." They are all functions which modify and direct personal behavior and self-expression. They are all parts of over-all self control.

These controls are not inherited —not part of our natural equipment; they are acquired or learned. This type of learning starts early

in life—long before school age—and although much of it is unconscious learning, it is vital to us throughout life.

It accounts for our attitudes toward ourselves and others, how we express aggression and hostility, how we react to authority and criticism, what and how much we are able to give and to receive in our relationships with other people.

Self control is essential if one is to live comfortably and happily with other people. And, as I mentioned, it must be learned. It is not always easy learning; it can be and frequently is, difficult or painful.

There is wide variation among people in the degree of self-control they possess and there can also be considerable variation in any one person from time to time and situation to situation. Most people have fairly adequate controls which, on the whole, are neither too lax nor too restrictive. Some persons however, are **under-controlled** and others are **over-controlled** in one or more areas of self-expression.

With a person whose learned controls over self-expression are well within the so-called average range, moderate amounts of alcohol will affect a slight reduction of inhibitions—he will feel a little more relaxed and comfortable, his current anxieties and tensions will be somewhat reduced, he will be a little less critical of others and of himself, so he will express himself more easily and spontaneously. A slight, but noticeable, difference in his overall performance occurs. We might compare it to the difference you feel in the performance of a car if you keep the accelerator steady when going down a hill. The car travels faster with less effort; however, the steering and the brakes are in good order and can be used effectively.

With the under-controlled person the acquiring of self-control has been difficult learning and not too well accomplished. He functions at the best of times too much on an impulsive level of expression. He isn't inhibited enough. When these controls are reduced by alcohol, there is poor or inadequate control of behavior. He tends to become noisy and boisterous, boastful and over-confident; little anxiety is felt for the consequences of immediate behavior, and feelings of aggression and hostility may be vigorously expressed. To continue our analogy, he is like a car going down-hill with faulty brakes and steering.

The over-controlled person, on the other hand, is one who is inhibited, too self-critical, unduly anxious about the consequences of his own behavior and about the reactions of people. He may be unable to give any adequate degree of expression to feelings of aggression and hostility, or to feelings of love and affection. He has learned to control self-expression to a painful degree. Alcohol in moderate amounts may reduce these controls to a point where this person feels reasonably comfortable with himself and others and is able to func-

tion at a more or less average level of self-expression.

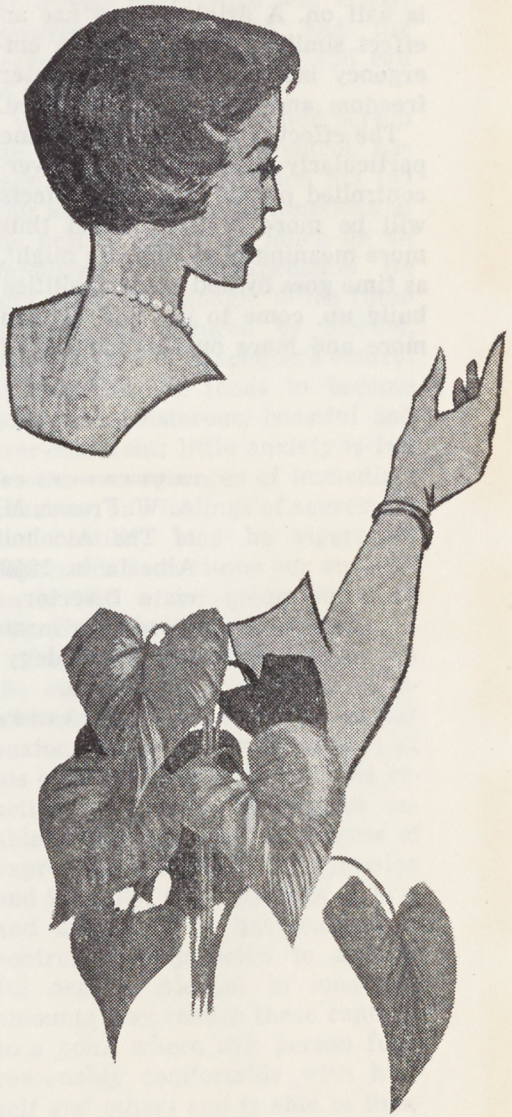
To refer to the car again; this chap is ordinarily like a driver trying to keep up to the flow of traffic when the car's emergency brake is half on. A drink or two has an effect similar to releasing the emergency brake—it permits greater freedom and ease of performance.

The effect of alcohol may become particularly significant to the over-controlled person, for these effects will be more gratifying and thus more meaningful to him. He might, as time goes by and responsibilities build up, come to use and depend more and more on this method of temporarily releasing the overly restrictive brakes.

THIS PAPER has been concerned with the psychological effects of small and medium amounts of alcohol. As we have seen, the effects on sensory response are consistent and measurable, but the more significant effects are on emotional functions—an area in which response is inconsistent and difficult to measure. Thus, only broad conclusions can be drawn regarding the effects of small and medium amounts of alcohol on the total behavior of any individual.

A. W. Fraser, M.A., joined the staff of The Alcoholism Foundation of Alberta in 1953 and is now Associate Director, Treatment. He received his masters degree in Clinical Psychology at the University of Alberta.

THE AL-ANON FA



THE AL-ANON Family Groups are a fellowship of the wives, husbands, relatives, and friends of members of Alcoholics Anonymous and of problem drinkers generally, who are banded together to solve their common problems of fear, insecurity, lack of understanding of the alcoholic, and of the warped personal lives resulting from alcoholism. The primary purpose of the Al-Anon Family Groups is to carry their helpful experience in gaining greater happiness to the non-alcoholic who seeks personal understanding of the problem of alcoholism and how to cope with its consequences.

The message of the Al-Anon Family Groups is a simple story of hope. It is the story of men and women who once felt hopelessly alone and powerless to deal with the alcoholism of their loved ones. Today these men and women no longer feel lost or lonely. They have learned that there are simple things that they can do to help themselves and their alcoholic partners.

Many who are now in Family

FAMILY GROUPS

Groups have already seen their loved ones achieve sobriety through AA; they know that life with a sober alcoholic can present special problems too. Others still have active problem drinkers in their homes. All members share the friendly bond of men and women who have turned from defeat and frustration to a new way of life in which positive constructive thinking is the keynote.

Historical Foreword

The Family Group idea is nearly as old as Alcoholics Anonymous itself. In the pioneering days of AA —1935-1941—wives and relatives of the recovering alcoholics began to realize they still had a common problem even though their partners had sobered up.

It was a serious dilemma which had two aspects. Wives saw they needed a deeper understanding of what alcohol had done to their partners. This much they could, of course, learn at AA meetings. But the more difficult problem was to understand what alcohol had done to them, the non-alcoholics. Just how had living with an alcoholic warped and deformed their own personalities? What did this have to do with the fact that it was often difficult to re-establish a happy life with the AA member? And if this was the condition, what could the non-alcoholic partners themselves do about it?

Of course they could go to AA meetings and listen. Each of them could try to apply the Twelve Steps to his or her life. A return to more

intense church and community work could be made. All of these ideas were tried, but a gap seemed to remain that simply would not be filled.

Therefore, in some of the early AA groups the non-alcoholics began to have meetings of their own to discuss their problems, the damage alcoholism had done them and what they could do about it. Though they had no set program or distinct society of their own, the results were beneficial indeed. Without knowing it, they were laying the foundation of the present day Al-Anon Groups.

As these pioneer groups became well established, they helped to start other groups. By 1949, the pent-up desire on the part of non-alcoholic partners to make a better life for their families really broke into the open. In this year, the AA General Headquarters received scores of inquiries from distracted wives and husbands of alcoholics. Many of these asked how they could start Family Groups. Some fifty Family Groups applied for listing in the new AA directory. But AA Headquarters, serving AA only, saw that it could not fill the needs of this new movement.

To meet this requirement for service, a number of husbands and wives of AA members in and about New York City formed a committee which later became the Al-Anon Family Groups Clearing House.

THE NEW movement mushroomed rapidly. With the establishment of a Post Office Box, the Clearing House Committee made contact with all the known Family Groups. It also answered the inquiries that AA Headquarters had received from individuals. A survey showed that Family Groups bore a variety of names and that many versions of the Twelve Steps were in use. The group purposes were not always clear. A few groups were simply auxiliaries of AA groups—dispensers of coffee and cakes.

Other groups were meeting to learn how to get along with their alcoholic partners, with very little emphasis on the Twelve Steps as applied to themselves. But even those groups which were forging ahead with high success needed encouragement and contact with each other. Moreover, literature about Family Groups was non-existent

After much correspondence and consultation, unity began to develop. The Groups voted to adopt the name "Al-Anon Family Groups" and they agreed that the Twelve Steps of Alcoholics Anonymous, virtually unchanged, should be the principles by which they would strive to conduct their lives. They authorized the Clearing House to handle over-all public relations and the production of literature was begun.

AT THIS point the Family Group movement came to public attention. Magazine articles, in many cases prepared with the assistance

of Clearing House members, drew a stream of inquiries. More volunteers rallied to the aid of the Clearing House Committee, as the influx of mail grew. New Groups sprang up and began to write the Clearing House about their problems.

Family Groups soon appeared overseas. By newsletters and mail, they were brought in contact with other groups throughout the world, and the Clearing House was able to direct travellers to them. The monthly newsletter was sent to lone members as well as groups, and with these isolated ones an encouraging personal correspondence was set up. A world directory was prepared and sent all groups. Additional literature was completed and more was projected.

By this time, in 1954, Clearing House activities had become strenuous. A new Group was being born somewhere about every three days. Even though more members volunteered to meet this situation, a paid staff became a necessity.

In order to handle its essential business affairs and modest bank balance more efficiently, the original Clearing House Committee is now incorporated as a non-profit unit known as the Al-Anon Family Group Headquarters, Inc.

The Family Groups and You

Why should you be interested in the Al-Anon Family Groups? Your answers to one or more of the following questions may determine whether or not the Family Groups can help you:

1. Are you the wife, husband, relative or friend of a problem drinker who still refuses help?
2. Are you concerned with a member of AA who is still having trouble with alcohol?
3. Though the alcoholic member of your family may now be sober, do you still feel that your home life is insecure or difficult?
4. Do you understand fully how alcoholism and its consequences may have warped your own thinking and your own personality?
5. Do you know that you can find understanding, friendship and help in the Al-Anon Family Groups: (a) regardless of whether the alcoholic member of your family has sobered up, or (b) whether he has made good in his business affairs, or (c) whether normal family relations have been restored?
6. Do you know that your own ability to face every life problem serenely and with a constructive attitude can be a most important factor in helping your alcoholic partner to achieve a full and happy recovery from problem drinking.

THE MEN and women of the Al-Anon Family Groups have had to face all these questions. They have had to take stock and realize that their partner's alcoholism has

often affected them, too. By learning from other Al-Anon members who have successfully dealt with all these problems, they have been able to create far happier personal relations and much better home lives even under difficult conditions.

RESEARCH REPORT

ESTIMATIONS OF THE DISTRIBUTION OF ALCOHOLISM IN ALBERTA

By Gwyneth Witney and R. W. Jones

A VARIETY of methods have been devised to estimate the number of alcoholics in any given geographic region. The most popular has been the Jellinek Estimation Equation, which uses cirrhosis deaths as the base datum. This use is based on several observations:

1. That over any given period of years, the rise or fall in cirrhosis deaths parallels the rise or fall in consumption of alcohol.
2. That cirrhosis of the liver is a fairly common disease among alcoholics and certain forms of the disease are clearly related to alcoholism.

If we make the following assumptions:

1. That the geographic distribution of cirrhosis deaths approximates the geographic distribution of alcoholism, and
2. That all deaths in which cirrhosis or one of its synonyms are mentioned are equally valid for the estimation of alcoholism,

then by a study of the distribution of cirrhosis deaths in Alberta we can make certain estimates of the prevalence and distribution of alcoholism in the Province. It must be realized, however, that serious inaccuracies may occur when, as is done in this study, estimations are made on the basis of small samples.

THE STUDY:

The sample was obtained by examining all the death certificates registered in Alberta during the

years 1956-1960. A total of 386 deaths were found in which cirrhosis or one of its synonyms was mentioned. Of these, four non-residents and thirteen children, all age 15 or under, were excluded from the sample. This left a sample of 369 deaths of Alberta adult residents who had had cirrhosis of the liver at the time of death.

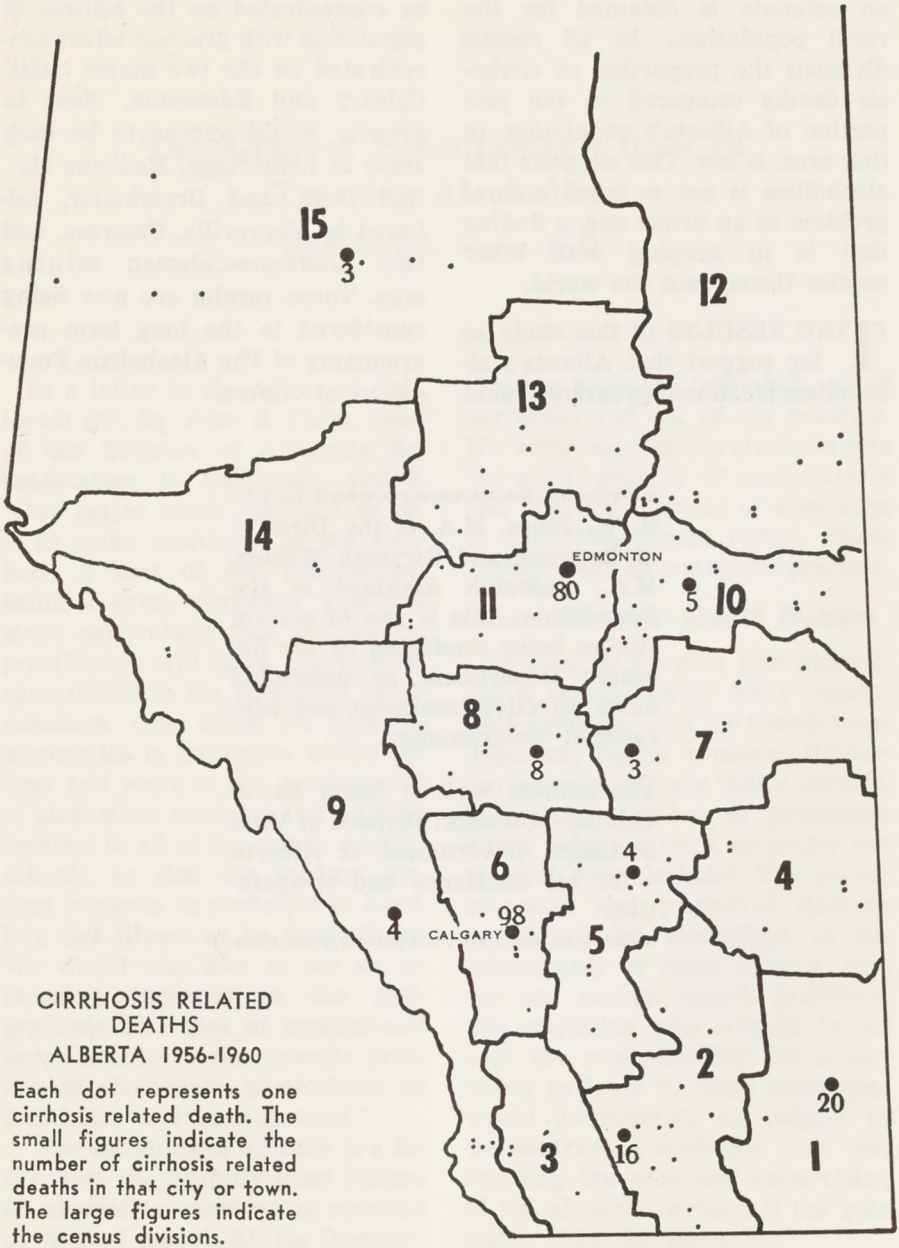
The places of residence of these 369 cases were plotted on a map of Alberta as shown. Looking at the map, the cities of Calgary and Medicine Hat (census division 1) appear to have rather large numbers of cirrhosis deaths. Edmonton and Lethbridge (census division 2) also have large numbers. However, their populations are also considerably larger, respectively, than Calgary and Medicine Hat. Red Deer (census division 8), Drumheller (census division 5), and Vegreville (census division 10) are also centers of clusters of cirrhosis deaths. Except for the Blairmore-Coleman mining area (cluster in the southern part of census divisions 9 and 3), there do not appear to be any other concentrations of such deaths.

If we examine the proportion of cirrhosis deaths for each Census Division compared to the proportion of Alberta's population in that area (Table I), several other facts become evident. It is clear that cirrhosis deaths, and presumably alcoholism, are not distributed uniformly across the province. With the exception of the non-drinking Mormon area (census division 3), the distribution of cirrhosis deaths compared to population suggests that the southern part of the province has a larger proportion of alcoholics than the northern part. Census Divisions 1, 6, and 9 are well above their proportion of population in proportion of cirrhosis deaths. Census Divisions 11 and 15 are well below. Census Division 11 is remarkable in this respect, in that the largest city in the province, Edmonton, is located in this Census Division.

If we remove the cirrhosis deaths occurring in the major Alberta cities (Calgary, Edmonton, Lethbridge, Medicine Hat, Red Deer, Camrose, and Drumheller) and the populations of these cities from their respective census divisions,

TABLE 1

Census Division	Cirrhosis Deaths 1956—1960 N.	%	Alberta Population 1956 %	High or Low
1	21	5.7	3.1	++
2	27	7.3	6.7	+
3	4	1.1	2.7	−−
4	6	1.6	1.3	+
5	14	3.8	3.4	+
6	103	27.9	21.2	++
7	10	2.7	3.6	−
8	18	4.9	5.7	−
9	10	2.7	1.5	++
10	22	6.0	6.3	−
11	92	24.9	28.8	−−
12	15	4.1	4.0	0
13	13	3.5	4.0	−
14	3	.8	1.4	−
15	11	3.0	6.3	−−



CIRRHOSIS RELATED DEATHS
ALBERTA 1956-1960

Each dot represents one cirrhosis related death. The small figures indicate the number of cirrhosis related deaths in that city or town. The large figures indicate the census divisions.

an estimate is obtained for the rural populations. In all census divisions the proportion of cirrhosis deaths compared to the proportion of Alberta's population, in that area, is low. This suggests that alcoholism is not so much a rural problem as an urban one, a finding that is in keeping with other studies throughout the world.

THE RESULTS of this study so far suggest that Alberta's alcoholism treatment program should be concentrated on the centres of population with greatest effort concentrated on the two major cities, Calgary and Edmonton. Next in priority would appear to be such areas as Lethbridge, Medicine Hat, Red Deer, and Drumheller, followed by Vegreville, Camrose, and the Blairmore-Coleman mining area. These results are now being considered in the long term programming of The Alcoholism Foundation of Alberta.

R. W. Jones, M.A. is the Director of Research and Gwyneth Witney, M.A., Research Assistant at the Foundation. This is one of several studies being conducted by the Research Department to determine more effective treatment and educational programming.

The authors wish to thank Mr. J. Colville—Director, Division of Vital Statistics, Government of Alberta —for his assistance and co-operation.

The General Practitioner's Role in Treating Alcoholism

By Robert A. Major, M.D.

In a letter to the editor of *California GP,* Dr. John R. Philp, chief of the Division of Alcoholic Rehabilitation in California, stated, "One major need, apparent to us, is to make treatment of the alcoholic a part of the professional skills of every physician. This will mean particularly that the general practitioner will have a prime responsibility in the treatment of alcoholism. One thing we hope to accomplish in California within the next few years is the development of alcoholism teaching and training services in all of the state's medical schools, so that the medical student becomes as proficient in handling this illness as he does others. We would also like to see an increasing emphasis on the postgraduate activities of professional organizations on the specific problem of alcoholism, particularly its treatment and management."

This enlightened attitude is a far cry from the pitifully short lecture on alcoholism most of us received in medical school. All too frequently, this lecture consisted of admonitions to keep the "drunks" out of our office and out of our practice. We were told that the alcoholic was "no good" socially or economically and that the presence of alcoholics in our office would reflect disadvantageously on our entire practice.

Fourth Greatest Health Problem

In spite of the fact that alcoholism is considered by many responsible agencies to be the fourth most important health problem, numerous surveys indicate that a surprisingly large number of physicians either refuse to treat, or prefer not to treat, the alcoholic. The social, economic and physical distress occasioned by alcoholism is exceeded only by heart disease, cancer and mental health problems. The physician who refused to accept the responsibility for supervising patients in these categories would undoubtedly be subject to well-warranted criticism. And yet, avoiding the care and supervision of the alcoholic patient is the rule rather than the exception.

In addition, stress and emotional

upset occasioned by close contact with the chronic alcoholic is often an important etiologic factor in physical disease affecting members of the alcoholic's family.

Therefore, the family physician should accept and retain the responsibility for the over-all management of the alcoholic patient. The various social and civic agencies and the various specialty practices can be of invaluable assistance in managing specific problems. As over-all supervisor of the patient, the doctor can select the agencies which are best suited to handle the patient's particular problem.

Infinite Physical Manifestations

The general practitioner frequently recognizes a problem involving alcoholism of which the patient or his family is totally unaware. The physical complaints which cause the alcoholic to seek medical help are almost infinite in number and these manifestations of alcoholism range all the way from chronic liver disease, gastric complaints and neurologic malfunctions to insomnia and abnormal nutritional patterns. In addition, the patient may present himself suffering from any one of dozens of bizarre, subjective complaints which result from the disturbed emotional pattern common in the alcoholic.

The general practitioner is frequently called to treat the alcoholic during, or immediately following, an acute episode of intoxication. Not only is the patient apt to be desperately ill, but the combative or maniacal phase experienced by some alcoholics may, if not vigorously treated, result in a custodial problem that prevents initiations of lifesaving measures. The patient seen at these times has two primary requirements. One is sleep and the other is the rapid restoration of a normal nutritional pattern.

The patient also must be afforded general supportive measures common to any other medical emergency involving physical collapse incidental to poisoning. The remarkable effectiveness of some of the new ataractic agents has brought about dramatic changes in treatment of the acutely intoxicated patient. Chlorpromazine and hydroxyzine used parenterally quiet the unmanageable patient, speed detoxication and make these patients as manageable as any others.

I found a recent evaluation that hydroxyzine (Vistaril, Pfizer) in a large number of patients safely brings brings the disturbed or combative alcoholic patient under control within 20 to 30 minutes when administered parenterally in 50- to 100-mg. doses. The effectiveness and safety inherent in hydroxyzine, both orally and parenterally, suggest that it may be the drug of choice for this phase of therapy.

Intensive Medical Measures

Once the patient is sleeping or has achieved the ability to cooperate, intensive medical measures may be initiated as directed. These measures may include fluid replacement, nutritional supplementation and such symptomatic treatment of the postalcoholic syndrome as may be indicated.

Whether or not the patient is treated at home or in the hospital is for the physician to decide. Such factors as the seriousness of the patient's general physical condition, economic status and, unfortunately, the availability of suitable facilities, will indicate this decision.

Due to the custodial problems presented by acutely intoxicated alcoholics, many hospitals either refuse to admit them or insist upon private duty nurses "around-the-clock." Tranquilizers may be of some help at this stage.

Whether a diagnosis of alcoholism is made incidental to an office visit when the patient presents himself with either a general medical problem, or the diagnosis is made during an acute episode, the family physician must, in good conscience, recognize that he possesses at this time the most important tool available for the solution to the problem of alcoholism. At this point the physician enjoys the confidence of the patient or the patient's family, or both. This is frequently denied to the specialist in psychiatry and the various civic and social workers.

The mere fact of the physician's attendance upon the patient implies a high degree of reliance upon the physician's skill and judgment and presupposes that the patient will be inclined to follow his recommendations.

Counseling Role Extremely Important

The medical management of either the acutely intoxicated alcoholic, or the management of medical problems secondary to alcoholism, is only in a general way connected with the treatment of the basic disease entity we have come to recognize as chronic alcoholism. This phase of therapy is important only insofar as it preserves the life of the patient so that the basic psychopathology or social pressure, or a combination of both, can be recognized and corrected.

Treatment of the chronic alco-

Robert A. Major, M.D., was awarded one of the 1960 Ross Awards of $1,000 for this article. Reprinted by permission of the author and publisher, *G.P.*, the official magazine of the American Academy of General Practice.

A course on Alcoholism is being given by the Foundation to fourth year medical students at the University and to internes from Edmonton City Hospitals. A booklet, Medical Treatment of the Alcoholic, is currently being prepared by the Foundation's Medical Advisory Committee.

holic can never be standardized. For this reason, the family physician must counsel the patient and his family and make selective referrals based upon the individual needs of the patient. Measures must be instituted to correct or treat any physical problems that may be present. At the same time, an evaluation must be made of the patient's social and physical environment. Much information pertinent to this is already available to the family physician. This should be made available to the psychiatrist or any of the other ancillary agencies as needed. Should the family physician lack this information, he must avail himself of the agencies which provide this material. These agencies may be social, civic or religious in nature, or may be a combination of all three.

In every case, it is desirable to have the above-mentioned information available prior to making a formal referral, because the physician's choice of ancillary agencies will be guided by each patient's individual pattern.

Changes in programming during the course of therapy, regardless of the agency or agencies chosen to assist, should be initiated or coordinated by the family physician.

Personnel of the ancillary agencies is highly specialized and cannot be expected to assume the responsibility for the over-all needs of the patient. However, every agency within the community should be utilized to the utmost of its ability to contribute to the patient's rehabilitation. It behooves every general practitioner to familiarize himself with these agencies.

Summary

The physician's ability to assume responsibility for alcoholic patients is predicated on his willingness to familiarize himself with the overall and multifaceted problems of alcoholism, and then to familiarize himself with all of the various therapies, agencies and individuals whose efforts might be required for the best possible care of the alcoholic patient.

By use of effective ataractic agents, which are both safe and effective, it is feasible to afford hospital care to the acutely intoxicated alcoholic with no material increase in the hospital's custodial function.

The general practitioner, perhaps more than other physicians, understands the importance of patient referral and recognizes the contribution that ancillary agencies can make toward an optimum standard of medical care. We therefore believe that the family doctor can make a significant social and professional contribution by preparing himself to care for, and then accepting for treatment, patients suffering from alcoholism. This contribution will materially help perpetuate the philosophy and concept of general practice.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**

  Professional advice and assistance on the problems of alcoholism.

- **AUDIO-VISUAL AIDS:**

  Films, tapes, records, and displays are available on loan.

- **CONFERENCES and SEMINARS:**

  To create a better understanding of the problems of alcoholism and methods of dealing with those problems.

- **INDUSTRIAL WORKSHOPS:**

  For the education of management, supervisory staffs, and general employees in Alberta industry.

- **ORIENTATION PROGRAMS:**

  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups.

- **PUBLICATIONS:**

  Progress, Digest on Alcohol Studies, and original brochures and pamphlets.

- **REFERENCE LIBRARY:**

  Books, pamphlets, and publications by authorities in the field of alcoholism.

- **SPEAKERS' BUREAU:**

  For professional, industrial, church, social, school, civic, and other groups requesting information.

The illustrations in Progress are by Harry Heine

COMMERCIAL PRINTERS LTD. EDMONTON

THE ALCOHOLISM FOUNDATION OF ALBERTA
9910 - 103 STREET, EDMONTON, ALBERTA

CANADA
POSTAGE PAID
PORT PAYÉ
2 c.
PERMIT NO. 719
EDMONTON